To:

ROYAL COMMISSION ON HEALTH SERVICES

Submission of:—

ONTARIO FEDERATION OF LABOUR - C.L.C.

TABLE OF CONTENTS

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TABLE OF CONTENTS
(continued)

SUMMARY OF
SUBMISSION OF ONTARIO FEDERATION OF LABOUR
TO THE
ROYAL COMMISSION ON HEALTH SERVICES

Guiding Principles in Health Care

Society has an obligation to ensure adequate health care.

Economic and working conditions are important factors in health care.

More emphasis should be placed on rehabilitation.

Unions and other voluntary organizations can and should play a leading role in any program of health care.

Existing Facilities

Existing plans not adequate to do the job, because they are not universal, they give limited coverage, and are unco-ordinated.

Extension of Private Plans

We are opposed to any extension of private plans because we are convinced that they are not geared to do the job.

Objectives of a Health Care Plan

This problem requires a whole new approach to the matter.

Plan should be universal, comprehensive in scope, and available to all without a means test.

It should provide high quality care and should put emphasis on prevention and rehabilitation.

Education

A broad program of education should accompany any plan.

Planning and Organization of Health Service

Research — Adequate research facilities should be made available.

Personnel A broad training program for personnel should be undertaken.

Financial incentives be made available to ensure equitable distribution of doctors and other personnel.

Facilities

More hospital space, along with convalescent and rehabilitation facilities be made available.

Group Practice

We advocate a program of group practice of medicine wherever possible.

Financing

Overall Cost

We have no estimate to make on the overall cost, but experience has shown it should not exceed 5% of the G.N.P.

Method of Remuneration

We are of the opinion that a salary system of payment is preferable to a "fee-for-service" basis of payment.

Method of Financing

We favour a grant-in-aid type of program.

We are opposed to any means test form of payment, also to any form of co-insurance form of payment.

Employer Contribution

That contribution for existing plans by employers be earmarked for any future plan.

Administration

Control of administration should be broadly based and not given to one group.

Appeal There should be an appeals procedure established.

Page 42.

Advisory Council

Any plan should have an advisory council representative of the whole community.

Advantage of a Public Program

We are of the opinion that only a public-sponsored program can do the job we have in mind in the health care field.

SUBMISSION TO THE ROYAL COMMISSION ON HEALTH SERVICES

Mr. Chairman and Members of the Commission:

1. We welcome the opportunity of bringing to your Commission the views of the Ontario Federation of Labour on this most important and complex problem. Our Federation is the provincial branch of the Canadian Labour Congress, comprising some 1,500 local unions with a combined membership of over 400,000. These local unions are located in every section of the province and cover workers in almost every field of industrial endeavour. We are therefore, no doubt, the largest single organization representing consumers of health services in this province.

Role of the Federation

2. Briefly, the role of our Federation is that of provincial legislative watchdog for our affiliated unions. Our program and policies are decided at annual conventions. This responsibility requires us to interpret existing legislation, encourage proper administration and recommend new legislation. These activities bring us into daily contact with problems of industrial health and safety, Workmen's Compensation, rehabilitation, public and private welfare, unemployment insurance, and all types of welfare and health plans. To administer this work we have a Welfare Department with a full-time Director.

Role of the Local Union

3. Generally speaking each local union negotiates and administers its own collective agreement, covering such matters as wages, hours of work, working conditions and welfare plans. Some have as much hospital, medical, surgical and allied coverage as it is possible to obtain under present arrangements, while others have very limited coverage and some still have no coverage of any kind.

Guiding Principles in Health Services

4. We agree with the definition of "health" provided by the World Health Organization as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

5. Social policy, therefore, should reflect an appreciation of the interrelation of health in its narrower sense with the many other factors bearing on the well-being of people. Thus, the concern of organized labour has been not only to enable workers to meet the financial demands of illness, but to promote an economic and social climate conducive to good health. In our view health services, despite their apparently unique problems and challenges, are very much a part of the emerging pattern of social services, pensions, income protection, and other forms of social organization through which we hope to achieve a maximum degree of health in its broadest sense.

6. It follows that the concern of our members in the area of health services as such encompasses the whole range of preventive measures, treatment and rehabilitation, including the maintenance

of family income during periods of disability. It is neither desirable nor logical to think that public concern with poor health begins and ends with any one aspect of health care.

7. We hold, as we have for many years, that it is only through public measures that well-organized and high-quality health services and facilities can be made available to all Canadians regardless of individual financial means.

8. While not attempting to set out here all the criteria for good health care, we feel that one further principle needs restating at this time. That is, that the well-being of the individual and his family should at all times be the primary concern of those engaged in the planning, organization and operation of health services. Considerations of efficiency, scientific progress or group welfare must have their place in this process, but it must at all times be kept in mind that these are means and not ends in themselves.

Causes of Poor Health

9. Everyone is susceptible to illness or accident. In the case of many ailments, their incidence appears to be similar or even higher among the well-to-do than among the underprivileged. Labour, however, has cause for particular concern with several factors causing particular health problems for workers:

10. Economic Circumstances - Inadequate family income is often reflected in crowded and unhygienic family quarters, bad nutrition, unsatisfactory heating and the other familiar attributes of subsistence living. The physical and mental infirmities arising from or aggravated by these conditions tend to be neglected until they reach an acute stage.

11. Working Conditions - Despite a wealth of discovery and innovation in industrial technology, many workers are exposed daily to health hazards in such forms as dust, fumes, temperature extremes, noxious chemicals, excessive noise or vibration and radiation. Lack of adequate safety precautions also continues to permit a great waste of human resources through industrial accidents resulting in mutilation, crippling disabilities and death. For documentation of this aspect of health in Ontario we would refer you to the recent Report of the Royal Commission on Industrial Safety under the chairmanship of His Honour Judge P. J. McAndrew.

12. Rehabilitation - Health problems in many instances are prolonged unnecessarily - and new problems created - by the lack of properly organized facilities for rehabilitation. The Workmen's Compensation Board has of course provided an excellent example of rehabilitation services co-ordinated with the treatment of disability. Beginnings have been made in the field of civilian rehabilitation, but neither provincial nor voluntary facilities are at present available to more than a very few of those needing this important type of health service.

Unions and Health Services

13. Organized labour has consistently and continuously advocated the introduction of a national health plan for the Canadian people. For years we were a lone voice crying in the wilderness. It is encouraging to note that now many other groups in our society are joining with us in proposing such a plan.

Consumer organizations particularly are united in calling for the establishment of a national health plan.

14. The most recent statement by Canadian organized labour is the resolution adopted in April, 1962 at the Canadian Labour Congress Convention in Vancouver, B.C., the main section of which reads as follows:

Resolved that the Canadian Labour Congress continue to press for the enactment of a public program of health care for the people of Canada that will satisfy the following standards:

1. It must be universally available without any economic obstacles between the services to be rendered and those who require them;

2. It must be comprehensive in scope, that is, it must provide preventive, diagnostic, curative and rehabilitative services, by the physician, specialist as well as general, dentist, nurse and other professional and auxiliary health care personnel, in the hospital, clinic or other institution, as well as in the doctor's office or the patient's home, as circumstances require, and include the provision of necessary drugs and appliances;

3. It must be so organized, nationally, provincially and regionally and foster the group practice of medicine, so as to provide health care services of the highest quality;

4. It must be equitably financed and free of deductible or co-insurance features;

5. It must contain the necessary means and incentives to establish a more equitable redistribution of existing personnel and facilities, add to such health care resources to the extent necessary and make provision for expanded medical education and research;

6. Its administration must be free of any undue control or influence by any interested group;

7. It must provide for an advisory council as part of its administrative structure, such council being representative of the interests of those who benefit from as well as those who provide health care services;

8. It must include an appeals procedure.

15. Much of the success of such plans as Blue Cross, P.S.I. and other insured medical and surgical schemes is attributable to a great degree to the support given these plans by the trade unions. While we now find that these plans no longer meet our needs, we would not deny that they have been of great assistance and have afforded health coverage to thousands who would not otherwise have had protection.

16. Being aware of the great gaps in existing plans, several unions have taken another bold step to try and close these gaps. Unions in the garment industry in Toronto now provide an annual medical check-up to all of their members. A group of unions in the Toronto area with the endorsation and active support of the Toronto and District Labour Council have just completed a two-year study of the group practice of medicine and are contemplating further steps in this project. The Steelworkers Union have completed plans for a comprehensive health centre for its members in Sault Ste. Marie. The Union has announced that a new $800,000 medical centre will be built, employing 20 or more doctors.

Existing Facilities

17. After years of experience with questions of health care we have come to the conclusion that a major re-organization of existing health services in Canada must be brought about and that simply adjusting present schemes either by extension or addition to existing plans is not good enough.

18. The fact that Canada is one of the very few remaining economically developed countries that has yet to establish such a program makes this need all the more obvious.

19. In Ontario today personal health services are being administered by a number of plans none of which provide complete coverage and worse still, there is no overall co-ordination of these plans. There is a wide variation in the distribution of general practitioners and specialists in medicine, and of hospital beds, there is a shortage of dentists, of nurses, of social workers, and of other grades of professional and auxiliary health personnel.

20. Existing facilities are a mixture of private, public and quasi-public institutions. In some instances, services are paid for on a fee for service basis, in others through prepayment under a group insurance plan, in still others under government financed or subsidized program or through a state social security system. One would assume that such a great array of schemes would provide adequate health protection but the facts are that they all give limited coverage and are by and large, uncoordinated and all too often unrelated.

Prepayment Plans

21. We would be among the first to concede that the prepayment plans have played an extremely important role in making health care available to a great many people who could not otherwise obtain it or could do so only under great financial difficulties. The growth of these plans as we mentioned previously has been in large measure the result of the collective bargaining activities of trade unions. Accordingly, if we are critical of the prepayment plans, as we intend to be, it is not because we are opposed to them in principle. It is that they can not, by their

very nature fulfil the objectives which we think should be set by the people of this country for their health services.

22. Our objections to prepaid plans are as follows:

1. Private plans are limited almost entirely to diagnostic and curative services. They are limited, generally speaking, to the services of the general practitioner and the specialist. They do not cover preventive or rehabilitative services.

2. Private plans have too many exclusions and restrictions. Certain medical and surgical procedures may be excluded entirely; others may be available only after a waiting period.

3. These plans frequently fail to cover the complete cost of the services required and the subscriber is left to carry a portion of the total cost himself.

4. Private plans disregard entirely preventive medicine and health education, and have seldom used their resources and experience for research in methods of improving health services.

5. These plans are not concerned with the quality of medical care. They show little or no interest in seeing that their subscribers obtain the best available treatment.

Extension of Private Plans

23. No doubt your studies will show the extent to which existing plans are now being used. A study of Welfare Coverage undertaken by the Ontario Civil Servants' Association and published in October, 1960 clearly demonstrates this point. (You will find this attached as Table 1.)

24. While this survey is by no means comprehensive enough to give an accurate picture of all industry in Ontario we believe that it does give a reasonable sampling of Ontario industry.

25. Not only are the present pre-payment plans limited in their extent of coverage, but they also have obvious shortcomings regarding the amount of actual medical care costs paid by these plans. A recent survey conducted by one of our affiliated unions provides definite evidence of the very limited effectiveness of the existing plans. We call your attention to the summary of findings of the survey included as Appendix B of this submission.

26. We reject the notion that the present inadequate patchwork of private agencies should be allowed to continue and become entrenched as quasi-public institutions, along with their unnecessary and costly duplication of administrative procedures, their disparities as to conditions of membership, range and quality of services, controls, etc.

27. The organized medical profession has proposed that coverage be provided through their own particular plan, that is, plans which the various provincial associations have initiated and sponsored. We do not deny the value of these plans, and in our opinion they compare favourably with those sponsored by the commercial carriers. It is one thing to have such plans exist as private agencies; it is another to have them enjoy public sanction and subsidy. We suggest that it would be against the public interest to permit these plans to obtain what would in effect be a monopoly over medical care and place control of such a monopoly

in the hands of the medical profession itself. It is surely contrary to sound public policy that an interested group should be allowed to wield authority and determine conditions in an area where it has a direct economic as well as a professional interest.

28. If there is to be universal coverage as we suggest, it seems an inescapable consequence of such a conclusion that the program should be administered by a public and not by a private agency.

Planning and Organization of Health Services

29. We will deal with the question of Planning and Organization of Health Services under the following headings:

- Research and Information Public Program
- Personnel
- Facilities
- Group Practice
- Financing:
  - (a) Overall Cost
  - (b) Methods of Remuneration
  - (c) Methods of Financing
  - (d) Grants in Aid
  - (e) Co-Insurance
  - (f) Employer Contribution
- Administration
- Appeals Procedure
- Advisory Council
- Advantages of a Public Program

Research and Information Public Program

30. The lack of information regarding health matters was brought forcibly to our attention when we started to gather information for this submission. We strongly believe that up-to-date information on a continuing basis concerning the extent of illness and disease in Canada, in relation to the amount and type of treatment, should be a part of any overall health plan.

31. While excellent research into such killing diseases as cancer and heart trouble are now in progress more financial help should be given to them.

Personnel

32. While the ratio of doctors to population in Ontario is as high, if not higher, in Ontario than in any other province in Canada the urbanization of the doctors accompanied with the growth of specialist private practice and a decline in the general private practice has resulted in either lack of service or poor service in the smaller centres. The national lack of dentists and nurses is also apparent in Ontario.

33. It is fully obvious that any expansion of health services will require that considerable attention be paid to training adequate personnel in all fields of health care work. In this regard the labour movement has over the years strongly supported an expansion of educational opportunities and in this instance supports the necessary incentives and facilities to encourage qualified students to enter the field of medicine. This could include scholarships, living allowances, student residences, expanded teaching facilities and the like.

34. We believe that the very marked trend towards specialization must be carefully assessed and reviewed with a view to maintaining a reasonable balance between the general practitioner and his specialist colleagues.

35. With respect to the distribution of personnel, we favour a system of incentives, financial and otherwise, which would over a period of time effect relocation on a more equitable basis.

36. In the matter of personnel, there is one other aspect that merits examination. We refer to the division of labour, as between professional and auxiliary occupations which will make possible the most effective use of skills. It may be that auxiliary personnel, such as nurses and dental hygienists, for example, should engage in some of the tasks which are now ordinarily performed by the professional superiors. Obviously such work would be done under supervision but, assuming proper training, it could contribute substantially to relieving the professional.

Facilities

37. The matter of facilities as a consideration of quality practice is a complex problem. It is complex because of the great variety in types of services and the changes in outlook concerning methods of treatment which are constantly taking place. It stands to reason that every practitioner, if he is to be effective, must have access to the best possible facilities and up-to-date equipment.

38. Years of planning and construction of hospitals has eased the acute shortage of a few years ago, but there is still room for improvement particularly in the smaller localities. There is, however, still a shortage of chronic, convalescent and nursing homesand mental health facilities. As we mentioned earlier, we have scandalously few facilities in the rehabilitation field.

Group Practice

39. We are advocates of group practice of medicine, because we have become convinced that through it the doctor can do his best work on behalf of his patient.

40. A number of factors have produced a situation encouraging the development of group practice. Among these are the growth of specialization, the increased body of knowledge in the field of medicine, the relatively heavy capital costs of modern medical equipment and the opportunities to practice better medicine through teamwork rather than through solo practice. Teamwork in medicine, already an established fact in many instances, must play a key role in a public health services program and in the improvement of health standards generally.

41. We are not for a moment suggesting that group practice is the only method through which health services can be provided. What we are suggesting is that the technology of modern medicine is such that group practice offers, wherever it is feasible, a better way of practicing good medicine.

42. Briefly, we are convinced that group practice under a comprehensive plan holds the following public advantages:

1. It enables insured families of moderate income to budget the total annual cost of virtually all health services they may require during the year. This applies whether prepayment is in the form of premiums or taxes.
2. There are no extra charges to deter families from using the preventive and early diagnostic services which are freely available within the group.
3. Family doctors and pediatricians in the medical group enjoy the unlimited use of laboratory, x-ray and specialist consultations and services.

4. Services of qualified specialists in all fields of medicine are also available to families without extra charge for as long a period as may be required by the nature of the illness.

5. Medical services are available on a 24-hour basis, but with a minimum of inconvenience to the individual practitioner.

6. Group practice is easily supervised and quality controls maintained by responsible medical boards.

7. Auxiliary services, including those of visiting nurses and social workers can be effectively integrated with group practice, ensuring a continuity and co-ordination of care that is impracticable under solo practice.

8. Family health education can be carried out and its effectiveness checked more thoroughly in a framework of group practice.

9. Persons obtaining services from the medical group do not constitute a wandering population to the same extent as they do under conditions of solo practice; hence there is likely to be a greater continuity of family health services.

43. While we are not qualified to interpret for this Commission the many published comments on medical aspects of group practice, we and our affiliated unions have been impressed by the overwhelming approval of the quality of health service provided through existing group plans of a comprehensive nature in the United States and elsewhere.

44. It is our conclusion, then, that a public-operated health plan should encourage group medical practice -- not to the exclusion of other forms of organization, but as a highly worthwhile solution to many problems of providing health services. We suggest that public encouragement might take the form of low-interest capital loans to new medical groups, subsidies to groups in under-doctored areas and possibly other financial incentives.

Financing

Overall Cost

45. Because of the many imponderables involved in the question of overall cost we do not at this time propose to make any estimates of costs of either the present volume of health services in Canada or of what it is likely to be the cost of the type of program that we propose here. We would, however, point out that there has been too much information about the supposedly tremendous cost involved fed to the general public about a comprehensive scheme. This has had the effect of discouraging people from even discussing this matter. We suggest that until more details of what form the scheme will take, then it will be impossible to put a price tag on it. What most people who have talked about the exorbitant cost have ignored is the amount already been spent on health services. You are undoubtedly aware of the study made by the International Labour Office (The Cost of Medical Care, I.L.O. 1959). The study, based on a survey of 14 countries including Canada, found that there was a very close similarity of percentage of national income spent on medical care no matter how it was

financed. For Canada, the I.L.O. gave a figure of 4.41 per cent, (1953), for the United States 4.48 per cent, (1953), for England and Wales 4.05 per cent, (1953-54), for New Zealand 4.56 per cent (1953) etc.

46. It would seem from this that social-security schemes do not necessarily increase national expenditures on medical care, they only replace expenditures from other sources, and the total cost is no higher than when medical care is provided by private practice supplemented by public funds in cases of need. When the British Health Scheme was being discussed prior to its implementation in 1948 the argument about high cost was used to discourage implementation of this plan, but experience has disproved this claim.

47. Whether and to what extent there will be any new money involved at all will depend in part on the economies that may be effected by a universal scheme in place of the present multiplicity of duplicated and overlapping ones, in part on the speed with which new personnel and new facilities are added to the supply and on the backlog of need. We are ready to assume that new money will be required. It seems inescapable that those who are not now getting the health care they require will seek to obtain it when services become available and to this extent there will be expenditures not now being made. It is open to question, however, whether this or a public program in general will result in a constant relative increase in costs. The I.L.O. study and the British experience do not seem to bear this out.

48. A universal health service program, comprehensive in scope and rationally organized, alive to new methods of treatment and organization of personnel, could effect real economies and thereby reduce costs. Some ways in which this could be done include greater emphasis on prevention and rehabilitation, extension of medical and nursing care in home and away from the hospital, higher productivity by better division of work through the stimulation of group practice, purchase of drugs through generic titles, visiting homemaker service for the aged now in hospitals for lack of a better place in which to be cared for and so forth. We do not profess to be experts in the administration of health service programs, but even laymen can see obvious advantages to be derived from a single unified program in place of the heterogeneous one now in effect.

Methods of Remuneration

49. There is one important aspect of costs which we feel requires elaboration. We refer to the method of remuneration of the professional and auxiliary occupations. In the case of physicians and dentists, however, the fee-for-service basis is widespread and its preservation is being sought. It would seem to us that a system of remuneration based on a payment for each service provided would, unless subject to a very considerable control, result in a much higher cost than some other form of payment. We do not consider that the fee-for-service basis is the best, either for the doctor or for the patient.

50. Regardless of the method of remuneration, we believe that doctors should be well paid. Their income should be sufficient for

them to enjoy a high standard of living. Remuneration should reflect the status of the doctor as a member of a highly regarded profession and his indispensable role in the community. It should be commensurate with his long period of training, his experience, time and effort spent on his work, and the occupational hazards of his practice. We suggest that the doctor should have access to procedures which would give him a voice in the determination of remuneration to be paid to him. We do not claim that the salary system of payment is perfection, but what we do say is that it is the best in terms of the Ontario situation.

51. While most of the discussion on the question of remuneration has centred around the doctor, we do not want to create the impression, however, that we are unmindful of the legitimate need of the many other occupations in the health field. We are of the opinion that any successful plan must assure that adequate wages and working conditions be enforced.

Methods of Financing

52. Our view is that the method of financing our proposed program should be such as to distribute the burden equitably; that is, on the basis of ability to pay. This would appear to preclude any system which would seek to cover costs through a premium payment or sales tax. Both of these have obvious regressive features.

Grants-in-Aid

53. In view of the fact that hospital insurance was introduced by means of grants-in-aid program to be taken up by the provinces, it seems likely that a similar procedure would be followed in the case of the remaining aspects of health services. If such is the

case, it is important that the federal legislation satisfy the following points: (1) the grants-in-aid should be of a proportion as to preclude the abstention of any province on the grounds that it could not afford to finance the balance of the cost, whether for service or for capital needs;

(2) the requirements that each participating province collect and make available to the Dominion Government prescribed statistical and other relevent data on the operation of the scheme, such as morbity rates, cost distributions, etc., which would make possible proper evaluation of the effectiveness of the scheme as well as the proper audit of its administration;

(3) a comprehensive range of services;

(4) an administrative structure which would give due weight to the point of view of the beneficiary and the lay administrator, inclusive of an appeal procedure, while recognizing the role and interests of the professional groups, especially on matters which they have technical competence;

(5) a program to increase personnel in the fields of health care and provide for their proper distribution throughout the country.

54. It is noteworthy that in case of hospital insurance, the provinces have adopted different methods of financing their programs.

Co-Insurance and Deterrent Charges

55. We take exception to the suggestion that financing be done by co-insurance or other deterrent charges.

56. Our objections to these factors of financing are two-fold. We object to them in the first instance because they place

a barrier between the person who requires medical care and the services that are required. We object to them as well on the grounds that they are regressive in character and place a burden for health care unfairly on the basis of ability to pay, at the same time eliminating the pooling risk which is characteristic of insurance.

57. The purpose of deterrent charges is obvious from its name. It is to discourage the would-be patient from making frivolous demands for services. Accordingly, the relatively well-to-do can indulge their whims while those financially less well-off are not able to. The deterrent charges thus tend to concentrate on lower income groups. Yet it is these low-income groups which need medical care.

58. Co-insurance is simply a device developed by the private insurance industry to reduce its cost on claims and to offer a premium rate which can more readily be sold. The insurance industry exists to make a profit. It is bound to take measures which will maximize its profit and reduce its potential loss. But the incentives of a public health program are entirely different. Profit is not a consideration, and the emphasis is on good health. Accordingly, to the extent that co-insurance is an obstacle to that goal, it is undesirable as well as inequitable.

Employer Contribution

59. In Ontario the provision of prepaid medical, surgical and other forms of health services for wage earners has been obtained through collective bargaining in the form of so-called fringe benefits. In some cases, the premium for this is paid

exclusively by the employer. In other cases, the typical arrangement is for a sharing of the premium by the employer and employees. In some cases the sharing is on a 50-50 basis; in others the employees pay a stipulated sum and the employer pays the difference. In any event, there has been established the feature of a contribution in whole or in part by the employer as part of the conditions of employment. We believe that this arrangement should be preserved. We suggest that consideration be given to an earmarked employer contribution on behalf of employees to replace the current employer contributions to private plans.

Administration

60. Our principle concern in regard to administration is to oppose any system of administration which would place control in the hands of one interested group. It would be contrary to the public interest, for example, if a health service program were to be administered exclusively by the medical profession. We are not concerned with the question of professional medical judgment, only the profession itself is competent to deal with that. But no program should be allowed to become a vehicle for the promotion of the self-interest of any group regardless of its nature. Professional representation should not only recognize the fact of several professions, but should be balanced by law representatives as well.

Appeals Procedure

61. We submit that any public program such as we advocate should possess an appeals procedure for those with grievances arising out of the operation of the program itself. There must

be safeguards against arbitrary rulings as well as against errors of commission or omission in its administration.

Advisory Council

62. Regardless of the methods of administration chosen, we regard it as an important part of the program that it should contain an advisory body. This body should consist of representatives of interested groups, both lay and professional. Representation should be sufficiently broad to include major elements of our community, such as labour, agriculture, business and so on.

Advantages of a Public Program

63. We have clearly indicated that what we propose is a public health services program, universally available without regard to means, comprehensive in its scope of service, with such services of the highest quality.

64. We have come to the conlusion, and we consider it a virtually self-evident proposition, that the status quo in health services is unsatisfactory and that merely to modify it, through extending the payments plan, for example, is to fall short of what is needed. A public program, properly planned and executed, would have these advantages:

(1) It would make health services available to everyone without regard to means, location, occupation, present state of health, age and other such factors which at one time or another or in one form or another now create a barrier between the could-be user of health service and those who would furnish it. Only a public program, established by legislative enactment, can hope to command the resources and engage in the planning which are the

basis of a comprehensive program of health service. Present arrangements have obviously failed either to provide the necessary resources or the needed care.

(2) Government alone has both the resources and the authority to finance and to plan a comprehensive program of health. It alone is able to establish fiscal policies which would make possible the financing of such a program on an equitable basis. We have in mind here orderly budgeting, cost projections and cost analysis, as well as the necessary and inevitable imposition of one form of tax or another, or of several forms of taxation, in order to provide the funds necessary to operate a program on a national scale. Furthermore, a program which provides for universal coverage must, of necessity, because of its dimension, require public control. It is inconceivable to us that the parliament of Canada should delegate its authority for a national program to private agencies, having in mind the fact that public funds would be used. It is significant that in no province has the legislature assigned to any private association the control over its hospital insurance program.

(3) As to planning, this has only too obviously not been a function of the private agencies in the health field if we are to think of planning in a global sense. The result of lack of planning is clear. The sheer complexity of the health structure makes planning imperative, and planning in turn requires government initiative and authority.

(4) The experience of other countries indicates that at some point in time the state finds it necessary to intervene. Such intervention has been the result of the inability of the existing programs to fulfil the task of providing adequate health care services. Canada is today one of the few remaining countries in the civilized world where the health needs of the people are not a matter of public control. This statement, of course, must be modified to the degree that hospital insurance is now available. But in terms of care by physician, dentist, and other related personnel, there is a gap so great that the very great importance of the hospital insurance program is lost sight of.

Conclusion

65. Mr. Chairman and Members of the Commission, we have attempted to put as briefly and concisely as possible our position on the matters before you, and we trust that this will be of assistance.

If there is any further information you require, we will make every effort to obtain it for you.

All of which is respectfully submitted.

Ontario Federation of Labour

David B. Archer
President

Douglas F. Hamilton
Secretary-Treasurer

May, 1962

APPENDIX "A" - 1

SUMMARY OF BENEFITS

		SERVICE PLANS				HOSPITAL			SURGICAL			LAB & X-RAY				ANAESTHETIST			DOCTORS CALLS						MAJOR MEDICAL			
	Number of Employees in Location	Blue Cross	P.S.I. Blue Plan	P.S.I. Brown Plan	Windsor Medical	$3 per day - Approx. $200 maximum	$3 per day - $350 and over maximum	$4 per day - $300 and over maximum	$200 maximum	$250 maximum	$300 max. - O.M.A. Tariff	$25 Unscheduled	$50 Scheduled	$50 Unscheduled	$100 Unscheduled	20% of Surgical Schedule	O.M.A. Tariff	$25-$35 maximum	1st-1st-$2-$3-$3 $150 maximum	1st-2nd-$2-$3-$3 $150 maximum	1st-3rd-$2-$3-$3 $150 maximum plus	1st-1st-$3-$3-$5 $200 maximum plus	1st-2nd-$3-$3-$5 $200 maximum plus	1st-3rd-$3-$3-$5 $200 maximum plus	In-Hospital - $3 $200 maximum	$25 Deductible $5,000 - 80-20% no base plan	$25 Deductible $5,000 - 80-20% over base plan	$50 Deductible $5,000 - 80-20% over base plan	$100 Deductible $10,000 - 80-20% over base plan
AURORA	449	-	271	-	-	-	-	271	23	-	155	23	-	-	-	-	-	-	-	23	-	-	-	155	-	-	-	-	-
COBOURG	456	-	98	-	-	-	-	-	124	-	234	-	-	234	-	234	-	-	-	-	-	234	-	-	-	-	124	-	-
FT. WILLIAM	1600	475	475	-	-	-	-	-	-	-	1096	-	-	-	-	-	1096	-	-	-	-	-	-	-	-	-	-	-	1096
KINGSTON	1033	709	612	-	-	-	-	-	97	192	-	-	-	-	-	-	-	192	-	97	-	192	-	-	-	-	-	88	-
LONDON	4913	2650	2650	-	-	667	-	-	667	-	-	-	-	-	-	-	-	667	667	-	-	-	-	-	-	1596	-	-	-
NORTH BAY	449	171	259	-	-	-	190	-	-	-	190	-	-	-	-	-	-	190	-	-	-	190	-	-	-	-	-	-	-
ORILLIA	1329	428	478	80	-	-	-	-	384	357	-	248	-	-	-	-	-	-	82	-	91	-	-	-	166	-	-	-	-
PENETANG	720	-	-	482	-	-	-	-	17	84	137	-	104	33	-	33	-	121	17	-	-	-	104	-	-	-	-	33	-
ST. THOMAS	838	-	-	131	-	-	-	-	-	179	444	-	-	-	-	-	-	623	-	-	-	-	-	-	-	-	-	-	-
SMITH'S FALLS	3241	2646	2667	39	-	70	-	-	-	200	70	-	-	-	-	-	-	-	-	200	-	-	-	-	70	265	-	-	-
THISTLETOWN	6681	-	-	-	-	-	5843	-	-	-	6681	-	-	-	5843	-	5843	-	-	-	-	5843	-	-	-	-	838	-	-
WHITBY	1191	1094	1137	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WINDSOR	1796	144	-	-	1796	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WOODSTOCK	1894	909	662	807	-	90	-	-	-	205	220	-	-	90	-	-	-	115	-	1027	-	-	-	90	-	-	-	-	-
OTHER PUBLIC SERVICE EMPLOYEES	3370	1370	1370	-	-	2000	-	-	-	-	2000	-	-	2000	-	-	-	-	-	-	-	-	-	-	-	-	2000	-	-
TOTAL	29960	10596	10679	1539	1796	2827	6033	271	1312	1217	11227	271	104	2357	5843	267	6939	1908	776	1347	91	6459	104	245	236	1861	2962	121	1096
						9131			13756			8575				9114			9248						1861	4179		

From a Job Evaluation done by William M. Mercer Ltd. for the
Civil Service Association of Ontario
published - October, 1960

AREA	NAME OF EMPLOYER	NATURE OF BUSINESS	NUMBER OF EMPLOYEES	TOTAL NO. OF EMPLOYEES
AURORA	Sterling Drug Mfg. Ltd.	Pharmaceutical preparations	271	
	Collis Leather Co.Ltd.	Tanners	155	
	Town of Aurora		23	449
COBOURG	Bird-Archer Co.Ltd.	Chemicals & Cleaning compounds	68	
	Mathews Conveyor Co.Ltd.)Port Hope)	Conveyors	238	
	H.W. Cooey Machine & Arms Co.Ltd.	Firearms	111	
	Town of Cobourg		39	456
FT.WILLIAM-PORT ARTHUR	Great-Lakes Paper Co.Ltd.	Newsprint	1,096	
	City of Ft. William		504	1,600
KINGSTON	Canadian Locomotive Co.Ltd.	Locomotives & diesels	206	
	A. Davis & Son Ltd.	Leather for shoe uppers	97	
	Kingston Whig-Standard Co.Ltd.	Newspaper	112	
	Frontenac Floor & Wall Tile Ltd.	Ceramic wall & floor tile	193	
	City of Kingston		425	1,033
LONDON	Silverwood Dairies Ltd.	Dairy Products	1,930	
	London Free Press	Newspaper	594	
	McCormick's Limited	Biscuits & confectionery	1,002	
	Kellogg Co. of Can.Ltd.	Cereal Manufacturing	667	
	City of London		720	4,913

NORTH BAY	Inspiration Mining & Development Co.Ltd.	Diamond drilling and mining supplies	88	
	Rahn Metals Limited	Castings & fabrications	53	
	Canadian Longyear Ltd.	Diamond core drills & accessories	118	
	City of North Bay		190	449
ORILLIA	Heywood-Wakefield Ltd.	Baby & doll carriages, bus seating & aluminum lockers	91	
	Tudhope Specialties Ltd.	Ice cream dishers & bakery equip.	80	
	Porcelain & Metal Products Ltd.	Advertising signs & toilet accessories	131	
	Fahralloy Canada Ltd.	Steel castings	248	
	Dorr-Oliver-Long Ltd.	Mining machinery	428	
	Otaco Limited	Farm equipment, boat trailers, heaters and toys	293	
	Town of Orillia		58	1,329
PENETANG	Midland Industries Ltd. (Midland)	Plastics	386	
	Pillsbury Canada Ltd. (Midland)	Flour, cake mixes, mill feed	117	
	Canadian Name Plate Co.Ltd. (Midland)	Decorative auto & appliance trim	200	
	Town of Penetanguishene		17	720
SMITH'S FALLS	Ottawa Citizen (Ottawa)	Newspaper	265	
	Dustbane Mfg. Co.Ltd.(Ottawa)	Sanitary supplies & equipment	60	
	Beach Foundry Ltd.(Ottawa)	Heating equipment	200	
	Dominion Loose Leaf Co.(Ottawa)	Printing and lithographing	70	

SMITH'S FALLS (cont)	City of Ottawa		2,607	
	Town of Smith's Falls		39	3,241
ST. THOMAS	Weatherhead Co. of Canada	Automotive & aircraft parts	239	
	Timken Roller Bearing Co.Ltd.	Roller Bearings	444	
	City of St. Thomas		155	838
THISTLETOWN (Toronto)	E.S.& A. Robinson(Canada)Ltd.	Paper products	290	
	Loblaw Groceterias Co.Ltd.	Food products	5,843	6,681
WHITBY-AJAX-OSHAWA	Dowty Equipment Co.(Ajax) of Canada	Landing gear,hydraulic pumps and special equipment	273	
	Fittings Ltd.(Oshawa)	Cast iron fittings	705	
	Coulter Mfg.Co.Ltd.(Oshawa)	Metals	160	
	Town of Whitby		53	1,191
WINDSOR-CHATHAM	Purity Dairies Ltd.(Windsor)	Dairy products	250	
	Assumption University(Windsor)		144	
	City ofWindsor		1,166	
	City of Chatham		236	1,796
WOODSTOCK	Ralston-Purina Ltd.	Livestock & poultry feed	205	
	Standard Tube & T.I.Ltd.	Steel tubing & school materials	560	
	York Knitting Mills Ltd.	Underwear, hosiery and yarn	1,027	
	City of Woodstock		102	1,894
OTHER PUBLIC SERVICE EMPLOYEES				
	Workmen's Compensation Board of Ontario		1,370	
	Sunnybrook Hospital		2,000	3,370
				29,960

APPENDIX "B"

SUMMARY OF A SURVEY BY THE STEELWORKERS UNION OF TWO GROUP INSURANCE PROGRAMS ESTABLISHED THROUGH COLLECTIVE BARGAINING WITH COMPANIES LOCATED IN HAMILTON, ONTARIO

In order to measure the comparative effects and value of two different approaches of voluntary health insurance plans, an extensive survey was conducted in Hamilton, Ontario during 1959 and 1960, among 921 families. Of this total, 482 families were those whose main breadwinner was employed at the Hamilton Works of the Steel Company of Canada, and who were covered for health insurance benefits through the collective bargaining agreement between the Company and the United Steelworkers of America. The plan covering these people was underwritten by the Prudential Life Assurance Company of America. The remaining 438 families were those of employees of the International Harvester Company of Canada, working in its Hamilton plant. These employees were also represented for collective bargaining purposes by the United Steelworkers of America, whose collective agreement with the Company provided for health insurance benefits underwritten by the Physicians' Services Incorporated, Blue Plan.

Each of the families in the Survey was extensively interviewed to determine patterns of health care as well as the amount of payments, in absolute as well as percentage of total expenses, paid by each of the underwriters.

The following is a brief summary of the findings of the Survey:

1. Almost exactly the same proportion of individuals reported one or more days of illness during the previous six month period.

2. The average annual number of days of illness was slightly higher for the P.S.I. sample (8.2 days) than for the Travelers' sample (7.0 days). In both cases, however, they are substantially below average days of illness shown in other surveys. This is partially explained by the fact that the samples of the present study contained a much lower percentage of "over age 65" individuals than did the other survey samples.

3. The incidence of illness was very unevenly and unequally distributed over the members of both groups. This, fundamentally, is the reason for the unevenness in medical care utilization as well as in medical care expenditures.

The average number of days of illness was 3.5 days for the Travelers' sample and 4.1 for the P.S.I. group. While almost 70 per cent of the overall group had no days of disability during the period, 14 per cent of the Travelers' group and 11 per cent of the P.S.I. group experienced twice the average of number of days of illness. Seven and $5\frac{1}{2}$ per cent respectively had four times the average number of days of illness; $2\frac{1}{2}$ and 3 per cent respectively had eight times the average number of days of illness.

4. The percentage of persons in both groups who had one or more contacts with a physician or surgeon during the previous six month period was almost the same for both sample groups. (About 60 per cent).

5. The distribution of the number of physician contacts during the previous six month period was wide and uneven. The average number of services during the previous six months for the P.S.I. sample was 2.78 and for the Travelers' group 2.23. However the range was between zero contacts and 45.

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7. [illegible] in both groups who had [illegible] during the previous [illegible] groups. (The [illegible]

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[illegible]

6. It is of very great importance that there appears to be little relationship between the number of physician contacts and the type of insurance program. This is true despite the fact that under one type of program there is no financial deterrent to almost unlimited use of physicians' services, while under the other program the family had to pay for most physician charges directly out of their own pockets. When the average number of services of each group is adjusted by the difference in the groups in the incidence and average length of disability, the results produced show an almost identical rate of use of physician services per disability day.

This seems to be in complete contradiction to the frequently heard, but undocumented complaint, that unless a financial deterrent is provided, then the use of physicians' services will increase astronomically. The present study provides substantial documentation to the fact that precisely the opposite is the case. The current results, then, are in keeping with and tend to confirm the findings of the 1955 Windsor survey which reached similar conclusions.

7. The percentage of individuals who visited a dentist during the previous six month period was relatively alike for both the Travelers and P.S.I. sample.

8. The frequency distribution for the utilization of dentists' services ranged broadly and there appeared to be no relationship between utilization of dentists' services and the type of insurance prepayment plan. The average number of dentists' visits per year was 1.49 for members of the Travelers' plan and 1.42 for P.S.I. subscribers.

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9. In relating the time of the last visit to both physician and dentist to the type of insurance coverage, there appears to be no correlation between length of time since last seeing a physician or dentist and the type of insurance.

10. Over 97 per cent of the families in the survey incurred some medical care expenses during the year. This varied according to size of family with 82 per cent of single member families and practically 100 per cent of families of two or more incurring expenses.

11. The average annual expenditure per family was $237.50. The average for Travelers' families was $256.40 and for P.S.I. families $216.70. Excluding the costs of non-prescription drugs, the corresponding figures are $204.60, $223.26 and $184.07.

12. The average annual medical expenditure represented 4.7 per cent of total annual family income. However, 2.7 per cent of the families spent no part of their income on medical care, while 2.9 per cent spent 20 per cent or more of their annual income on medical care expenses.

13. The distribution of the costs among the components of medical care expenses was very close between the Travelers and P.S.I. families. The distribution was as follows:

	Travelers	P.S.I.
Physicians' fees	42.7	40.0
Dentists' fees	18.2	13.5
Prescription drugs	17.1	19.4
Non-prescription drugs	12.9	14.5
Eye examination & eye glasses	5.1	5.2
Supplemental hospital charges	1.8	3.0
X-Ray and laboratory charges	1.0	1.1
Nursing charges	.5	1.5
"Other" costs	.6	1.8
	100.0	100.0

14. There was a very uneven distribution of costs among the families in the survey. While 6.7 per cent spent $10 or less per year on medical care, 9.1 per cent of the families spent over $500 for medical care during the year. This uneven distribution of costs among families comes as no surprise, but adds additional confirmation to the findings included in the Report of the Committee on the Cost of Medical Care; The Nationwide Survey of Medical Costs and Voluntary Health Insurance; and The Canadian Sickness Survey.

15. The survey indicated a very close relationship between total expenses and size of family, but there appeared to be no apparent relationship between expenditures and family income.

16. There was a very significant difference between the two groups in regard to the numbers receiving any insurance benefits at all from the plan during the year. While 65.1 per cent of the families received some benefit from the P.S.I. plan, only 38.2 per cent of the families under the Travelers' plan received any benefit from it.

17. The average total annual insurance benefit to the P.S.I. families was $56.93 while for the Travelers' families it was $33.16.

18. The aggregate total insurance benefits represented 12.9 per cent of aggregate total health expenditures for Travelers' families and 23.5 per cent for P.S.I. families.

19. The aggregate total insurance benefits represented 14.9 per cent of aggregate health expenditures less non-prescription drugs for Travelers' families and 27.7 per cent for P.S.I. families.

20. The aggregate total insurance benefits represented 30.4 per cent of aggregate expenses for doctors' bills only for Travelers' families and 58.7 per cent for P.S.I. families.

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